

CunardCare Guest Protection



Cover Page

Cunard Line has partnered with Aon Affinity and Nationwide Mutual Insurance Company to provide our guests with travel protection. This document holds all of the relevant information you will need in regard to your travel protection plan.

Please review the following three (3) sections:

- **Cancellation Fee Waiver Program**
Provided by Cunard Line
- **Travel Protection Plan Certificate**
Including Applicable State Exceptions provided by Nationwide Mutual Insurance Company and Affiliated Companies, Columbus, OH
- **Worldwide Emergency Assistance Services**
Provided by On Call International

Cancellation Fee Waiver Program

The following Cancellation Fee Waiver Program is provided by Cunard Line and is not an insurance benefit.

The CunardCare Cancellation Fee Waiver Program offers our valued guests the opportunity to receive a refund from Cunard Line (beyond the standard refund policy published in our cruise brochure) for those otherwise non-refundable cruise vacation-related costs prepaid to Cunard Line, should you cancel or interrupt your cruise vacation for the reasons stated below.

CunardCare Cruise Cancellation & Interruption Fee Waiver

(For Specified Reasons).....Cash Refund Up to Total Cruise Vacation Cost,
maximum limit of \$50,000

This Cancellation Fee Waiver Program is an addendum to your cruise Ticket Contract. Through the Cancellation Fee Waiver Program, Cunard Line will waive their standard cancellation provision and refund to you **IN CASH** the otherwise non-refundable value of the unused portion of your prepaid cruise vacation, should you or your traveling companion need to cancel or interrupt your cruise vacation for any one of the following reasons (subject to the restrictions noted below**):

1. sickness, injury or death to yourself, a traveling companion, or members of either of your immediate families which is diagnosed and treated by a physician at the time your cruise vacation is terminated;
2. involvement in a traffic accident en route to departure that causes you to miss your cruise;
3. your home is made uninhabitable by a natural disaster such as flood, earthquake, hurricane, volcano, tornado, wildfires or blizzard;
4. being called to serve jury duty or subpoena.

CunardCare Cancellation Fee Waiver refunds are also provided if you are charged a change in occupancy/ single supplement charge as a result of your traveling companion's cancellation due to one of the reasons cited above.

Important: Please advise your travel agent, Cunard Line and the Program Administrator as soon as possible in the event of cancellation. Refunds will not be provided for additional charges incurred that would have not been charged had you notified these parties as soon as reasonably possible.

**Please note the following restrictions:

Cunard will not waive their cancellation fee and provide a cash refund, should you cancel or interrupt your cruise vacation for any of the following reasons:

- a condition that first presents, worsens, becomes acute, or has symptoms causing a person to seek diagnosis, care or treatment, or prompts a change in medication, during the 60 days before the Cancellation Fee Waiver Program is purchased;
- a condition related to: elective abortion; use of alcohol or drugs other than as prescribed by a doctor; psychological disorders (unless hospitalization is required) or pregnancy (unless hospitalization is required);
- business, contractual, or educational obligations of you, a family member or a traveling companion;
- declared or undeclared war or act of war;
- service in the armed forces of any country;
- unlawful acts (committed by you, a family member or a traveling companion); or
- any specified reason cited previously that occurs prior to the purchase of the Cancellation Fee Waiver Program.

Furthermore, for cruise vacation costs exceeding \$50,000 per guest, Cunard will provide cruise credits equal to the otherwise non-refundable cancellation fees which exceed the \$50,000 cash reimbursement limitation.

Where To Report Cancellations & Interruptions:

Contact your travel agent, Cunard Line or the Program Administrator IMMEDIATELY to advise of your situation and to avoid any non-reimbursable expenses due to late notification. The Program Administrator will send you a form that must be completed by you and the treating doctor (if applicable). Instructions will be provided as to what other information may be needed if cancellation/interruption is caused by a non-medical reason. The Program Administrator can be contacted 24 hours a day online at www.travelclaim.com or Monday – Friday 8 AM – 10 PM (Eastern) and Saturdays 9 AM – 5 PM (Eastern) by calling 1-800-323-3153 or 1-516-342-7262.

SPECIAL CUNARDCARE CRUISE VACATION PROTECTION CANCELLATION ENHANCEMENT**CunardCare “ANY REASON” Travel Credits.....Up to 75% of the non-refundable prepaid Cruise Vacation Cost****Provided by Cunard Line**

In the event that you choose to cancel for a reason not authorized above or for a reason that is otherwise restricted, at any time up until departure, and you have purchased CunardCare, Cunard Line will provide you a travel credit equal to 75% of the non-refundable value of your cruise vacation prepaid to Cunard Line, for your use toward a future cruise vacation. This additional enhancement is offered by Cunard Line as a special service to guests that purchase this ticket contract Cancellation Fee Waiver Program Addendum and is available only if purchased prior to final payment (for the cruise vacation). Certain restrictions on the use of these travel credits (such as blackout periods) may apply. To be eligible for credits, notification of cancellation must be given to Cunard Line prior to the ship's departure. Once you've cancelled with Cunard Line, please contact the Program Administrator at **1-800-323-3153** regarding travel credits.



Nationwide®

CONFIRMATION OF COVERAGE

Underwritten by: Nationwide Mutual Insurance Company and Affiliated Companies, Columbus, OH

Plan Number: NWECP01

Program Name: CunardCare Guest Protection

Your plan is administered by: Aon Affinity Travel Practice
900 Stewart Avenue
Garden City, NY 11530-9998

Listing of Benefits

Maximum Benefit

Accident Medical Expense	
Maximum Benefit for Medical Expenses	\$20,000 per Trip
Maximum Benefit for Dental Expenses	\$1,000 per Trip
Baggage Delay	
Maximum Benefit	\$500 per Trip
Baggage/Personal Effects	
Maximum Benefit	\$3,000 per Trip
Emergency Evacuation and Repatriation of Remains	
Maximum Benefit	\$50,000 per Trip
Sickness Medical Expense	
Maximum Benefit for Medical Expenses	\$20,000 per Trip
Trip Delay	
Maximum Benefit	1,000 per Trip

Notes:

Traveling Companion shall be defined as a person whose name appears with Yours on the same Travel Arrangements, and who, during the Trip, will accompany You.

Trip means **Travel Arrangements** as defined in this certificate.

Travel Protection Plan Certificate



Nationwide®

Nationwide Mutual Insurance Company
One Nationwide Plaza
Columbus, Ohio 43215

This Certificate of Insurance describes all of the travel insurance benefits, underwritten by Nationwide Mutual Insurance Company and herein referred to as the Company. The insurance benefits vary from program to program. Please refer to the accompanying Confirmation of Coverage. It provides You with specific information about the program You purchased.

This Certificate of Insurance is issued in consideration of the enrollment and payment of any premium due. All statements in the enrollment are representations and not warranties. Only statements contained in a written enrollment will be used to void insurance, reduce benefits or defend a claim.

All premium is non-refundable after a ten (10) day review period from the date of purchase in the event You have not incurred any claims during that time.

NO DIVIDENDS WILL BE PAYABLE UNDER THIS CERTIFICATE.

The President and Secretary of Nationwide Mutual Insurance Company witness this Certificate.

Secretary

President

TRAVEL PROTECTION CERTIFICATE EXCESS INSURANCE

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**NATIONWIDE MUTUAL INSURANCE COMPANY
TRAVEL PROTECTION INSURANCE CERTIFICATE**

GENERAL DEFINITIONS

Throughout this document, when capitalized, certain words and phrases are defined as follows:

Accident means a sudden, unexpected, unintended, specific event that occurs at an identifiable time and place, but shall also include exposure resulting from a mishap to a conveyance in which You are traveling.

Accidental Injury means Bodily Injury caused by an Accident (of external origin) being the direct and independent cause in the Loss and that 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. The injury must be verified by a Physician.

Actual Cash Value means the lesser of the replacement cost or the purchase price less depreciation.

Additional Expenses means any reasonable expenses for meals and lodging as well as local transportation and essential phone calls that were necessarily incurred as the result of a Hazard and that were not provided by the Common Carrier or other party free of charge.

Bodily Injury means identifiable physical injury that is caused by an Accident and is independent of disease or bodily infirmity.

Business Partner means an individual who: (a) is involved in a legal partnership; and (b) is actively involved in the day-to-day management of the business.

Carry-On Baggage means a piece of baggage that has not been checked and is owned by and accompanies You while traveling on a Common Carrier.

Certificate of Insurance means this document, and any endorsements, riders or amendments that will attach during the period of coverage.

Checked Baggage means a piece of baggage that accompanies You for which a claim check has been issued to You by a Common Carrier.

Common Carrier means any land, sea, and/or air conveyance operating under a valid license for the transportation of passengers for hire. Taxis and limousines are not Common Carriers as defined herein.

Company means Nationwide Mutual Insurance Company.

Confirmation of Coverage means the document that outlines Your benefits and Maximum Benefit amounts.

Covered Expenses means expenses incurred by You that are for Medically Necessary care or treatment; due to Sickness or Bodily Injury; prescribed, performed or ordered by a Physician; Reasonable and Customary Charges incurred while insured under this Certificate; and that do not exceed the Maximum Benefit limits shown in the Confirmation of Coverage, under each stated benefit.

Cruise means any prepaid sea arrangements made by You.

Dependent Child(ren) means Your child (or children), including an unmarried child, stepchild, legally adopted child or foster child who is: (1) less than age nineteen (19) and primarily dependent on You for support and maintenance; or (2) who is at least age nineteen (19) but less than age twenty-three (23) and who regularly attends an accredited school or college; and who is primarily dependent on You for support and maintenance.

Domestic Partner means a person with whom You reside and can show evidence of cohabitation (including the shared responsibility for basic living expenses) for at least the previous six (6) months and has an affidavit of domestic partnership, if recognized by the jurisdiction within which You reside.

Economy Fare means the lowest published rate for a round trip economy ticket.

Effective Date means 12:01 A.M. local time, at Your location, on the day after the required premium for such coverage is received by the Company or its authorized representative.

Family Member means Your or a Traveling Companion's legal or common law spouse, ex-spouse, parent, legal guardian, step-parent, grandparent, parents-in-law, grandchild, natural or adopted child, step-child, children-in-law, brother, sister, step-brother, step-sister, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, Business Partner or Domestic Partner.

Hazard means:

- a) Any delay of a Common Carrier (including Inclement Weather).
- b) Any delay by a traffic accident en route to a departure, in which You or a Traveling Companion is not directly involved.
- c) Any delay due to lost or stolen passports, travel documents or money, Quarantine, hijacking, unannounced Strike, natural disaster, civil commotion or riot.

Hospital means a facility that:

- (a) holds a valid license if it is required by the law;
- (b) operates primarily for the care and treatment of sick or injured persons as in-patients;
- (c) has a staff of one or more Physicians available at all times;
- (d) provides twenty-four (24) hour nursing service and has at least one registered professional nurse on duty or call;
- (e) has organized diagnostic and surgical facilities, either on the premises or in facilities available to the hospital on a pre-arranged basis; and
- (f) is not, except incidentally, a clinic, nursing home, rest home, drug or physical rehabilitation facility or convalescent home for the aged, or similar institution.

Inclement Weather means any severe weather condition that delays the scheduled arrival or departure of a Common Carrier.

Insured means the person who enrolled for coverage and whose premium was paid under the Policy.

Land/Sea Arrangements means pre-paid land and/or sea arrangements made by the Travel Supplier.

Loss means Bodily Injury, Sickness or damage sustained by You, while coverage is in effect, in consequence of happening of one or more of the occurrences against which the Company has undertaken to indemnify You.

Maximum Benefit means the largest total amount that the Company will pay under any one benefit for You, as shown on the Confirmation of Coverage.

Medically Necessary means a service or supply that: (a) is recommended by the attending Physician; (b) is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; (c) could not have been omitted without adversely affecting Your condition or quality of medical care; (d) is delivered at the most appropriate level of care and not primarily for the sake of convenience; and (e) is not considered experimental unless coverage for experimental services or supplies is required by law.

Other Insurance means any one of the following types of policies or plans that provides benefits for Hospital confinement, medical expenses for you at the time of Loss on Your Effective Date of coverage, and such policy or plan requires You to pay any applicable Deductible and/or portion of coinsurance: individual, group or blanket insurance plans; HMO's, PPO's, POS's, EPO's, employer organization plans, employee benefit organizational plans, or other arrangements of benefits for persons of a group.

Participating Organization means a travel agency, tour operator, cruise line, airline or other organization that applies for coverage under the Policy and remits the required premium to the Company.

Physician means a licensed practitioner of medical, surgical or dental services, acting within the scope of his/her license. The treating Physician may not be You, a Traveling Companion or a Family Member.

Policy means the Group Master Policy including the application and any endorsements, riders or amendments that will attach during the period of coverage.

Pre-Existing Condition means an illness, disease, or other condition during the sixty (60) day period immediately prior to the Effective Date for which You, a Traveling Companion, a Family Member booked to travel with You: 1) exhibited symptoms that would have caused one to seek care or treatment; or 2) received or received a recommendation for a test, examination,

or medical treatment; or 3) took or received a prescription for drugs or medicine. Item (3) of this definition does not apply to a condition that is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the sixty (60) day period before the Effective Date.

Quarantine means Your strict isolation imposed by a Government authority or Physician to prevent the spread of disease. An embargo preventing You from entering a country is not a Quarantine.

Reasonable and Customary Charges means charges commonly used by Physicians in the locality in which care is furnished.

Scheduled Departure Date means the date on which You are originally scheduled to leave on the Trip.

Scheduled Return Date means the date on which You are originally scheduled to return to the point of origin or to a different final destination.

Sickness means an illness or disease of the body that: 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. An illness or disease of the body that begins prior to the Effective Date of coverage is not a Sickness as defined herein and is not covered by this Certificate unless it suddenly worsens or becomes acute after the Effective Date.

Sound Natural Teeth means teeth that are whole or properly restored and are without impairment, periodontal or other conditions and are not in need of the treatment provided for any reason other than an Accidental Injury. For purposes of this Certificate, teeth previously restored with a crown, inlay, onlay, or porcelain restoration or treated by endodontics, except amalgam or composite resin fillings, are not considered Sound Natural Teeth.

Strike means any unannounced labor disagreement that interferes with the normal departure and arrival of a Common Carrier.

Travel Arrangements means: (a) transportation; (b) accommodations; and (c) other specified services arranged by the Travel Supplier for the Trip.

Travel Supplier means Cunard Line.

Traveling Companion means a person who has coordinated Travel Arrangements or vacation plans with You, intends to travel with You during the Trip and is further described on the Confirmation of Coverage. Note, a group or tour leader is not considered a Traveling Companion unless You are sharing room accommodations with the group or tour leader.

Trip means a trip or class of trips as described on the Confirmation of Coverage.

Unforeseen means not anticipated or expected and occurring after the Effective Date of Your coverage.

You or Your refers to the Insured.

GENERAL PROVISIONS

The following provisions apply to all coverages:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

CONTROLLING LAW - Any part of this Certificate that conflicts with the state law where the Certificate is issued is changed to meet the minimum requirements of that law.

GOVERNING JURISDICTION – The insurance regulatory agency and courts of the jurisdiction in which You are located shall have jurisdiction over the individual or group insurance coverage as if such coverage or plan were issued directly to You.

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company.

ASSIGNMENT - This Certificate is not assignable, whether by operation of law or otherwise, but benefits may be assigned.

WHEN YOUR COVERAGE BEGINS - Provided:

- (a) coverage has been elected; and
- (b) the required premium has been paid.

All coverage will begin on the Scheduled Departure Date, or the actual departure date if change is required by a Common Carrier, when You depart for the first Travel Arrangement (or alternate Travel Arrangement if You must use an alternate Travel Arrangement to reach Your Trip destination) for Your Trip.

WHEN YOUR COVERAGE ENDS - Your coverage will end at 11:59 P.M. local time on the date that is the earliest of the following:

- (a) the Scheduled Return Date as stated on the travel tickets;
- (b) the date You return to Your origination point if prior to the Scheduled Return Date;
- (c) the date You leave or change the Trip (unless due to Unforeseen and unavoidable circumstances covered by the Policy);
- (d) if You extend the return date, coverage will terminate at 11:59 P.M., local time, at Your location on the Scheduled Return Date, unless otherwise authorized by the Company in advance of the Scheduled Return Date;
- (e) the date Your Trip is cancelled;
- (f) when Your Trip exceeds one hundred twenty (120) days.

EXTENDED COVERAGE - Coverage will be extended under the following conditions, should they occur during the journey to the return destination or to a different destination:

- (a) When You commence air travel from Your origination point: (i) within two (2) days before the commencement of the Land/Sea Arrangements, coverage shall apply from the time of departure from the origination point; or (ii) greater than two (2) days before the commencement of the Land/Sea Arrangements, the extension of coverage shall be provided only during Your air travel.
- (b) If You return to Your origination point: (i) within two (2) days after the completion of the Land/Sea Arrangements, coverage shall apply until the time of return to the origination point; or (ii) greater than two (2) days after the completion of the Land/Sea Arrangements, the extension of coverage shall be provided only during Your air travel.
- (c) If You are a passenger on a scheduled Common Carrier that is unavoidably delayed up to five (5) days in reaching the final destination, coverage will be extended for the period of time needed to arrive at the final destination.

EXCESS INSURANCE LIMITATION - The insurance provided by this Certificate shall be in excess of all other valid and collectible insurance or indemnity. If at the time of the occurrence of any Loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of Loss, over the amount of such Other Insurance or indemnity, and applicable Deductible.

The following provisions apply to all benefits except Baggage/Personal Effects and Baggage Delay:

PAYMENT OF CLAIMS - The Company, or its designated representative, will pay a claim after receipt of acceptable Proof of Loss.

Benefits for Loss of life are payable to Your beneficiary. If a beneficiary is not otherwise designated by You, benefits for Loss of life will be paid to the first of the following surviving preference beneficiaries:

- a) Your spouse;
- b) Your child or children jointly;
- c) Your parents jointly if both are living or the surviving parent if only one survives;
- d) Your brothers and sisters jointly; or

e) Your estate.

All other claims will be paid to You. In the event You are a minor, incompetent or otherwise unable to give a valid release for the claim, the Company may make arrangement to pay claims to Your legal guardian, committee or other qualified representative.

Any payment made in good faith will discharge the Company's liability to the extent of the claim.

The applicable benefit amount will be reduced by the amount of benefits, if any, previously paid by Other Insurance policies. In no event will the Company reimburse You for an amount greater than the amount paid by You.

NOTICE OF CLAIM - Written notice of claim must be given by the claimant (either You or someone acting for You) to the Company or its designated representative within twenty (20) days after a covered Loss first begins or as soon as reasonably possible. Notice should include Your name, the Travel Supplier's name and the Plan number. Notice should be sent to the Company's administrative office, or to the Company's designated representative.

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PHYSICAL EXAMINATION AND AUTOPSY - The Company, or its designated representative, at its own expense, have the right to have You examined as often as reasonable necessary while a claim is pending. The Company, or its designated representative, also has the right to have an autopsy made unless prohibited by law.

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Certificate for any Loss other than Loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of six (6) percent per annum from the thirtieth (30th) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

The following provisions apply to Baggage/Personal and Baggage Delay coverages:

NOTICE OF LOSS - If Your property covered under this Certificate is lost, stolen or damaged, You must:

- (a) notify the Company, or its authorized representative as soon as possible;
- (b) take immediate steps to protect, save and/or recover the covered property;
- (c) give immediate notice to the carrier or bailee who is or may be liable for the Loss or damage;
- (d) notify the police or other authority in the case of robbery or theft within twenty-four (24) hours.

PROOF OF LOSS - You must furnish the Company, or its designated representative, with Proof of Loss. This must be a detailed sworn statement. It must be filed with the Company, or its designated representative, within ninety (90) days from the date of Loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event later than one year from the time proof is otherwise required.

SETTLEMENT OF LOSS - Claims for damage and/or destruction shall be paid after acceptable proof of the damage and/or destruction is presented to the Company and the Company has determined the claim is covered. Claims for lost property will be paid after the lapse of a reasonable time if the property has not been recovered. You must present acceptable Proof of Loss and the value involved to the Company.

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, either You or the Company can make a written demand for an appraisal. After the demand, You and the Company will each select their own

competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

BENEFIT TO BAILEE - This insurance will in no way inure directly or indirectly to the benefit of any carrier or other bailee.

ACCIDENT MEDICAL EXPENSE

The Company will reimburse benefits up to the Maximum Benefit shown on the Confirmation of Coverage, if You incur necessary Covered Medical Expenses as a result of an Accidental Injury that occurs during the Trip. You must receive initial treatment for Accidental Injuries while on the Trip. All services, supplies or treatment must be received within fifty-two (52) weeks of the date of the Accident.

Covered Medical Expenses are expenses incurred for necessary services and supplies: (a) listed below; and (b) ordered or prescribed by the attending Physician as Medically Necessary for treatment, that are limited to:

- (a) the services of a Physician;
- (b) charges for Hospital confinement and use of operating rooms; Hospital or ambulatory medical-surgical center services (this will also include expenses for a Cruise ship cabin or hotel room, not already included in the cost of Your Trip, if recommended as a substitute for a Hospital room for recovery from an Accidental Injury);
- (c) charges for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
- (d) ambulance service;
- (e) drugs, medicines and therapeutic services.

The Company will not pay benefits in excess of the Reasonable and Customary Charges. The Company will not cover any expenses provided by another party at no cost to You, or already included within the cost of the Trip.

The Company will pay benefits up to the Maximum Benefit shown on the Confirmation of Coverage for dental emergency treatment for Accidental Injury to Sound Natural Teeth. Both the Accidental Injury and the dental Emergency Treatment must occur during the Trip.

BAGGAGE DELAY (Outward Journey Only)

The Company will reimburse You for the expense of necessary personal effects, up to the Maximum Benefit shown on the Confirmation of Coverage, if Your Checked Baggage is delayed or misdirected by a Common Carrier for more than twenty-four (24) hours, while on a Trip.

You must be a ticketed passenger on a Common Carrier.

Additionally, all claims must be verified by the Common Carrier who must certify the delay or misdirection and receipts for the purchases must accompany any claim.

BAGGAGE/PERSONAL EFFECTS

The Company will reimburse You up to the Maximum Benefit shown on the Confirmation of Coverage, if You sustain Loss, theft or damage to baggage and personal effects during the Trip, provided You have taken all reasonable measures to protect, save and/or recover the property at all times. The baggage and personal effects must accompany You during the Trip. The police or other authority must be notified within twenty-four (24) hours in the event of theft.

This coverage is subject to any coverage provided by a Common Carrier and all other valid and collectible insurance indemnity and shall apply only when such other benefits are exhausted.

There will be a per article limit shown on the Confirmation of Coverage.

There will be a combined Maximum Benefit limit shown on the Confirmation of Coverage for the following:
jewelry; watches; articles consisting in whole or in part of silver, gold or platinum; furs; articles trimmed with or made mostly of fur; personal computers; cameras and their accessories and related equipment.

The Company will pay the lesser of the following:

- (a) Actual Cash Value at time of Loss, theft or damage to baggage and personal effects; or
- (b) the cost of repair or replacement in like kind and quality.

EXTENSION OF COVERAGE

If You have checked Your property with a Common Carrier and delivery is delayed, coverage for Baggage/Personal Effects will be extended until the Common Carrier delivers the property.

EMERGENCY EVACUATION

The Company will pay benefits for Covered Expenses incurred, up to the Maximum Benefit shown on the Confirmation of Coverage, if an Accidental Injury or Sickness commencing during the course of the Trip results in Your necessary Emergency Evacuation. An Emergency Evacuation must be ordered by a Physician who certifies that the severity of Your Accidental Injury or Sickness warrants Your Emergency Evacuation.

Emergency Evacuation means:

- (a) Your medical condition warrants immediate Transportation from the hospital where You are first taken when injured or sick to the nearest Hospital where appropriate medical treatment can be obtained;
- (b) after being treated at a local Hospital, Your medical condition warrants Transportation to where You reside, to obtain further medical treatment or to recover; or
- (c) both (a) and (b), above.

Covered Expenses are reasonable and customary expenses for necessary Transportation, related medical services and medical supplies incurred in connection with Your Emergency Evacuation. All Transportation arrangements made for evacuating You must be by the most direct and economical route possible. Expenses for Transportation must be:

- (a) recommended by the attending Physician;
- (b) required by the standard regulations of the conveyance transporting You; and
- (c) authorized in advance by the Company or its authorized representative.

Transportation of Dependent Children: If You are in the Hospital for more than two (2) days following a covered Emergency Evacuation, the Company will return Your unattended Dependent Children accompanying You on the scheduled Trip, to their home, with an attendant if necessary.

Transportation to Join You: If You are traveling alone and are in a Hospital alone for more than seven (7) consecutive days or if the attending Physician certifies that due to Your Accidental Injury or Sickness, You will be required to stay in the Hospital for more than seven (7) consecutive days, upon request the Company will bring a person, chosen by You, for a single visit to and from Your bedside.

Transportation services are provided if authorized in advance by the assistance provider, and are limited to necessary Economy Fares less the value of applied credit from unused travel tickets, if applicable.

Transportation means any Common Carrier, or other land, water or air conveyance, required for an Emergency Evacuation and includes air ambulances, land ambulances and private motor vehicles.

The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

REPATRIATION OF REMAINS

The Company will pay the reasonable Covered Expenses incurred to return Your body to Your primary residence if You die during the Trip. This will not exceed the Maximum Benefit shown on the Confirmation of Coverage. This benefit is provided if authorized in advance by the assistance provider.

Covered Expenses include, but are not limited to, expenses for embalming, cremation, casket for transport and transportation.

SICKNESS MEDICAL EXPENSE

The Company will reimburse You, up to the Maximum Benefit shown on the Confirmation of Coverage, if You incur Covered Medical Expenses as a result of a Sickness that first manifests itself during the Trip. You must receive initial treatment for the Sickness while on the Trip. All services, supplies or treatment must be received within fifty-two (52) weeks following the onset of the Sickness.

Covered Medical Expenses are expenses incurred for necessary services and supplies: (a) listed below; and (b) ordered or prescribed by the attending Physician as Medically Necessary for treatment, that are limited to:

- (a) the services of a Physician;
- (b) charges for Hospital confinement and use of operating rooms; Hospital or ambulatory medical-surgical center

services (this will also include expenses for a Cruise ship cabin or hotel room, not already included in the cost of Your Trip, if recommended as a substitute for a Hospital room for recovery from a Sickness);
(c) charge for anesthetics (including administration); x-ray examinations or treatments, and laboratory tests;
(d) ambulance service; and
(e) drugs, medicines and therapeutic services.

The Company will not pay benefits in excess of the Reasonable and Customary Charges. The Company will not cover any expenses provided by another party at no cost to You or already included within the cost of the Trip.

TRIP DELAY

The Company will reimburse You for Covered Expenses, up to the Maximum Benefit shown on the Confirmation of Coverage, if You are delayed, while coverage is in effect, en route to or from the Trip for three (3) or more hours due to a defined Hazard.

Covered Expenses:

- (a) Any prepaid, unused, non-refundable land and water accommodations;
- (b) Any Additional Expenses incurred;
- (c) An Economy Fare from the point where the You ended Your Covered Trip to a destination where You can catch up to the Covered Trip; or
- (d) A one-way Economy Fare to return You to Your originally scheduled return destination.

LIMITATIONS AND EXCLUSIONS

The following exclusions apply to Trip Delay, Sickness Medical Expense, Accident Medical Expense, Emergency Evacuation and Repatriation of Remains:

Loss caused by or resulting from:

1. Pre-Existing Conditions, as defined in the Definitions section (except Emergency Evacuation and Repatriation of Remains);
2. war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not), civil war;
3. participation in any military maneuver or training exercise;
4. piloting or learning to pilot or acting as a member of the crew of any aircraft;
5. mental or emotional disorders, unless Hospitalized;
6. being under the influence of drugs or intoxicants, unless prescribed and used in accordance with the instructions provided by a Physician;
7. commission or the attempt to commit a dishonest, fraudulent or criminal act;
8. dental treatment except as a result of an injury to Sound Natural Teeth;
9. any non-emergency treatment or surgery, routine physical examinations, hearing aids, eye glasses or contact lenses;
10. pregnancy and childbirth (except for complications of pregnancy), except if Hospitalized;
11. curtailment or delayed return for other than covered reasons;
12. traveling for the purpose of securing medical treatment;
13. care or treatment for which compensation is payable under Worker's Compensation Law, any Occupational Disease law; the 4800 Time Benefit plan or similar legislation;
14. care or treatment that is payable under any Other Insurance policy;
15. Accidental Injury or Sickness when traveling against the advice of a Physician;
16. a Loss that results from an illness, disease, or other condition, event or circumstance that occurs at a time when Your coverage is not in effect.

The following exclusions apply to Baggage/Personal Effects and Baggage Delay:

The Company will not provide benefits for any Loss or damage to:

1. animals;
2. household effects and furnishing;
3. antiques and collector's items;
4. eyeglasses, sunglasses or contact lenses;
5. artificial teeth and dental bridges;
6. hearing aids;
7. artificial limbs and other prosthetic devices;
8. keys, cash, stamps, securities and documents;
9. tickets;
10. credit cards;
11. professional or occupational equipment or property, whether or not electronic business equipment;

12. sporting equipment if loss or damage results from the use thereof;
13. musical instruments;
14. retainers and orthodontic devices.

Any Loss caused by or resulting from the following is excluded:

1. breakage of brittle or fragile articles;
2. wear and tear or gradual deterioration;
3. insects or vermin;
4. inherent vice or damage while the article is actually being worked upon or processed;
5. theft or pilferage while left unattended in any vehicle;
6. mysterious disappearance;
7. property illegally acquired, kept, stored or transported;
8. insurrection or rebellion;
9. imprudent action or omission;
10. property shipped as freight or shipped prior to the Scheduled Departure Date.

COORDINATION OF BENEFITS

Applicability

The Coordination of Benefits ("COB") provision applies to This Plan when You have health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

The benefits of This Plan:

- (a) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
 - (b) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.
- This reduction is described further in the section entitled Effect on the Benefits of This Plan.

Definitions

Plan is written on a form that is on an expense incurred basis that provides benefits or services for, or because of, medical or dental care or treatment. "Plan" includes:

- (a) group insurance and group remittance subscriber contracts;
- (b) uninsured arrangements of group coverage;
- (c) group coverage through HMO's and other prepayment, group practice and individual practice Plans; and
- (d) blanket contracts, except blanket school accident coverages or a similar group when the Policyholder pays the premium.

"Plan" does not include individual or family:

- (a) insurance contracts;
- (b) direct payment subscriber contracts;
- (c) coverage through HMO's; or (d) coverage under other prepayment, group practice and individual practice Plans.

This Plan is the parts of this blanket contract that provide benefits for health care expenses on an expense incurred basis.

Primary Plan is one whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either:

- (a) the Plan either has no order of benefit determination rules, or it has rules that differ from those in the contract; or
- (b) all Plans that cover the person use the same order of benefits determination rules as in this contract, and under those rules the Plan determines its benefits first.

Secondary Plan is one that is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this contract decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan that, under the rules of this contract, has its benefits determined before those of that Secondary Plan.

Allowable Expense is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private Hospital room and a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

Claim is a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

- (a) services (including supplies);
- (b) payment for all or a portion of the expenses incurred; or
- (c) a combination of (a) and (b).

Claim Determination Period is the period of time that must not be less than twelve (12) consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

- (a) whether other insurance exists; and
- (b) how much each Plan will pay or provide.

For the purposes of this contract, Claim Determination Period is the period of time beginning with the Effective Date of coverage and ending twelve (12) consecutive months following the date of Loss or longer as may be determined by the Proof of Loss provision.

Order of Benefit Determination Rules

When This Plan is a Primary Plan, its benefits are determined before those of any other Plan and without considering another Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of any other Plan only when, under these rules, it is secondary to that other Plan.

When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan that has its benefits determined after those of the other Plan, unless:

- (a) the other Plan has rules coordinating its benefits with those of This Plan; and
- (b) both those rules and This Plan's rules, as described below, require that This Plan's benefits be determined before those of the other Plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- (a) Nondependent/Dependent Rule. The benefits of the Plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan that covers the person as a dependent.
- (b) Longer/Shorter Length of Coverage Rule. The benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four (24) hours after the first ended. Thus, the start of a new Plan does not include: (a) a change in the amount or scope of a Plan's benefits; (b) a change in the entity that pays, provides or administers the Plan's benefits; or (c) a change from one type of Plan to another. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Effect on the Benefits of This Plan When it is Secondary

The benefits of This Plan will be reduced when it is a Secondary Plan so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses, not otherwise paid that were incurred during the Claim Determination Period by the person for whom the Claim is made. As each Claim is submitted, This Plan determines its obligation to pay for Allowable Expenses based on all Claims that were submitted up to that point in time during the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Company has the right to decide which facts are needed. The Company may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Company any facts we need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Company may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Company is more than the Company should have paid under this COB provision, the Company may recover the excess from one or more of: (a) the persons we have paid or for whom we have paid; (b) insurance companies; or (c) other organizations.

Non-complying Plans

This Plan may coordinate its benefits with a Plan that is excess or always secondary or that uses order of benefit determination rules that are inconsistent with those of This Plan (non-complying Plan) on the following basis:

- (a) If This Plan is the Primary Plan, This Plan will pay its benefits on a primary basis;
- (b) if This Plan is the Secondary Plan, This Plan will pay its benefits first, but the amount of the benefits payable will be determined as if This Plan were the Secondary Plan. In this situation, our payment will be the limit of This Plan's liability; and
- (c) if the non-complying Plan does not provide the information needed by This Plan to determine its benefits within thirty (30) days after it is requested to do so, the Company will assume that the benefits of the non-complying Plan are identical to This Plan and will pay benefits accordingly. However, the Company will adjust any payments made based on this assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

STATE MANDATED LANGUAGE GROUP CERTIFICATE NSHTC 2500

Alaska

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No such action shall be brought after expiration of three years from the date a claim is denied in whole or in part.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be void if You have concealed or misrepresented any material fact or circumstance on the application in obtaining the Certificate. All statements and descriptions in an application shall be considered to be representations and not warranties. The misrepresentations, omissions, concealment of facts and incorrect statements may not prevent a recovery under the Certificate unless they are fraudulent, material to the acceptance of the risk or the hazard assumed, or the Company in good faith would not have issued the Certificate or would have issued it differently if the true facts had been known.

Under the section entitled **GENERAL PROVISIONS**, the following provisions are added:

FIRST PARTY CLAIM PAYMENT – Undisputed portions of first party claims will be paid within thirty (30) working days of Company receipt of Proof of Loss.

EXAMINATION UNDER OATH – You are allowed to have legal representation present when examined under oath.

INSURANCE WITH OTHER INSURERS - If:

- 1) You have other Travel Insurance in effect at the same time as this Certificate covering the **Trip** as described on Your Confirmation of Coverage, and
- 2) This Certificate is not in excess of all other valid and collectible insurance or indemnity.

We will pay only the proportion of the loss that the limit of liability that applies under this policy bears to the total amount of insurance covering the loss.

NSHTC 2200 AK

Arkansas

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action may be brought to recover on the plan within sixty (60) days after written Proof of Loss has been given. No such action shall be brought to recover on the Certificate prior to the expiration of the time allowed by law after Proof of Loss has been furnished in accordance with requirements of this Certificate.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

Under the section entitled **GENERAL PROVISIONS**, the following provision is added:

Inquiries or complaints regarding this Certificate may be submitted to the Arkansas Insurance Department in writing or by phone. Contact information is:
Arkansas Insurance Department
Consumer Services Division
1200 W. 3rd Street
Little Rock, Arkansas 72201-1904
Telephone: 800-852-5494 or 501-371-2640

NSHTC 2200 AR

Connecticut

A copy of the Master Policy, form number NSHTC 2000 is available to you upon request.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing. However, after two (2) years from the date of enrollment, no misstatements made during enrollment may be used to void the coverage of deny any claim for loss incurred after the two (2) year period.

Under the section entitled **GENERAL PROVISIONS**, the **SUBROGATION** provision is deleted in its entirety and replaced with the following:

SUBROGATION - To the extent allowed by law, We, upon making any payment or assuming liability of recovery for You against any person or corporation, may bring an action in Your name to enforce such rights. This provision does not apply to judicial awards of damages.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** is deleted in its entirety. The reference to “Excess Insurance” on page 1 is deleted.

Under the section entitled **GENERAL PROVISIONS**, the **TIME OF PAYMENT OF CLAIMS** provision is deleted in its entirety and replaced with the following:

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Certificate for any Loss other than Loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of fifteen (15) percent per annum from the thirtieth (30th) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount

of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

Under the section entitled **GENERAL PROVISIONS**, the following **DISPUTE RESOLUTION** provision is added:

DISPUTE RESOLUTION - If we are unable to resolve any disputes with You regarding this Certificate, you may file a written complaint with the State of Connecticut Insurance Department, PO Box 816, Hartford, CT 06142-0816 Attn: Consumer Affairs. The written complaint must contain a description of the dispute, the purchase price of the covered product subject to the Plan, the cost of the product and a copy of the Certificate.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusions 5, 6, and 7 are deleted in their entirety and replaced by the following:

5. Mental, nervous, emotional, or personality disorders in any form whatsoever unless You are hospitalized for three (3) consecutive days or more after the Certificate Effective Date;
6. Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as now or hereafter amended, unless prescribed by a Physician for You. (Accidental ingestion of a poisonous food substance or consumption of a controlled drug is not excluded.)
7. Commission or the attempt to commit a felony.

NSHTC 2200 CT

District of Columbia

The fact page of the Certificate is revised by the addition of the following:

THIS IS A LIMITED BENEFIT POLICY, PLEASE READ CAREFULLY

Under the section entitled **GENERAL DEFINITIONS**, the following is added to the definition of **Medically Necessary**:

The fact that a **Physician** may prescribe, authorize, or direct a service does not of itself make it **Medically Necessary** by the Individual or group Policy.

Under the section entitled **GENERAL PROVISIONS**, the provision entitled **DISAGREEMENT OVER SIZE OF LOSS** is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, either You or the Company can make a written demand for an appraisal. After the demand, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

The following is added: Wherever the term "spouse" appears in the Certificate it is amended to also include "legal partner".

NSHTC 2200 DC

Georgia

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD - Your coverage may be denied and Your Certificate may be cancelled if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

NSHTC 2200 GA

Hawaii

The Certificate to which this rider is attached is amended as follows:

Under the section entitled **LIMITATIONS AND EXCLUSIONS**:

Exclusion 10 is deleted in its entirety.

NSHTC 2200 HI

Idaho

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Hospital** is deleted in its entirety and replaced with the following:

Hospital means a provider that is a short-term, acute, or general hospital that:

1. is a duly licensed institution;
2. in return for compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick person by or under supervision of Physicians;
3. has organized departments of medicine and major surgery;
4. provides 24-hour nursing service by or under the supervision of registered graduate nurses; and
5. is not other than incidentally: a) a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanatorium, place for rest, or place for the aged; b) a place for the treatment of mental illness; c) a place for the treatment of alcoholism or drug abuse, place for the provision of hospice care; or d) a place for the treatment of pulmonary tuberculosis.

Under the section entitled **GENERAL PROVISIONS**, the following **APPEALS** provision is added:

You may appeal any decision made by the Company to the Idaho Department of Insurance by contacting:

Idaho Department of Insurance

Consumer Affairs

700 W. State Street, 3rd Floor

P.O. Box 83720

Boise, ID 83720-0043

1-800-721-3272

www.DOI.Idaho.gov

NSHTC 2200 ID

Illinois

The Certificate to which this rider is attached is amended as follows:

Under the section entitled **GENERAL DEFINITIONS**, the following definition is added:

Under the Influence of Intoxicants is defined and determined by the laws of the state or jurisdiction where the loss or cause of loss was incurred.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD - Your coverage may be denied and Your Certificate may be cancelled if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

Under the section entitled **GENERAL PROVISIONS**, the **SUBROGATION** provision is deleted in its entirety and replaced with the following:

SUBROGATION - The Company is assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits the Company paid for that sickness or injury. You are required to furnish any information or assistance, or provide any documents that the Company may reasonably require in order to exercise the Company's rights under this provision. This provision applies whether or not the third party admits liability.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** provision is deleted in its entirety and replaced with the following:

OTHER INSURANCE - Except as provided in the Coordination of Benefits Section of this form, if there is other valid and collectible insurance in effect covering a loss insured under this policy, this policy will share proportionately with such other insurance.

Under the section entitled **GENERAL PROVISIONS**, the following **COMPLAINT** provision is added:

Should you have general complaints regarding this insurance, you may submit your complaint in writing to the following address:

Illinois Division of Insurance
Consumer Division
Springfield, Illinois 62767

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 7 is deleted in its entirety and replaced with the following:

7. Commission of or attempt to commit a felony or to which a contributing cause was being engaged in an illegal occupation by You.

NSHTC 2200 IL

Maine

Under the section entitled **GENERAL DEFINITIONS**, the definitions of **Accidental Injury** and **Actual Cash Value** are deleted in its entirety and replaced with the following:

Accidental Injury means Bodily Injury caused by an Accident being the direct and independent cause in the Loss and that 1) requires a physical examination and medical treatment by a Physician and 2) commences while Your coverage is in effect. The injury must be verified by a Physician.

Actual Cash Value means the lesser of the replacement cost at the time of loss, less the value of physical depreciation. Physical depreciation is a value determined by standard business practice.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be cancelled or denied if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing. You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

Under the section entitled **GENERAL PROVISIONS**, the **WHEN YOUR COVERAGE ENDS** provision is deleted in its entirety and replaced with the following:

WHEN YOUR COVERAGE ENDS - Your coverage will end at 12:01 A.M. local time on the date that is the earliest of the following:

- (a) the day after the Scheduled Return Date as stated on the travel tickets;
- (b) the day after the date You return to Your origination point if prior to the Scheduled Return Date;
- (c) the day after the date You leave or change the Trip (unless due to Unforeseen and unavoidable circumstances covered by the Policy);
- (d) if You extend the return date, coverage will terminate at 12:01 A.M., local time, at Your location on the day after the Scheduled Return Date, unless otherwise authorized by the Company in advance of the Scheduled Return Date;
- (e) the day after the date Your Trip is cancelled;
- (f) when Your Trip exceeds one hundred twenty (120) days.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an umpire. Any figure agreed to by two (2) of the three (3) (the appraisers and the umpire) will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share

equally with the **Company** the cost for the umpire and the appraisal process.

Under the section entitled **GENERAL PROVISIONS**, the **TIME OF PAYMENT OF CLAIMS** provision is deleted in its entirety and replaced with the following:

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Certificate for any Loss other than Loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the **Company** of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate of 1.5% per month from the thirtieth (30th) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. **You** or **Your** assignee shall be notified by the **Company** or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

NSHTC 2200 ME

Maryland

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years from the date it accrues.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be cancelled and any claims denied if, whether before or after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety.

NSHTC 2200 MD

Mississippi

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the following is added to the **PAYMENT OF CLAIMS** provision:

Upon receipt of a written notice of claim, **We** will furnish any forms required to file a Proof of Loss. If **We** fail to furnish such forms within 15 days after receipt of notice of claim, the claimant shall be deemed to have complied with Proof of Loss requirements upon submitting written proof of loss covering the occurrence within the timeframe for Proof of Loss outlined in the Certificate.

Under the section entitled **GENERAL PROVISIONS**, the **TIME OF PAYMENT OF CLAIMS** provision is deleted in its entirety and replaced with the following:

TIME OF PAYMENT OF CLAIMS - Indemnities payable under the Certificate for any loss will be paid immediately upon receipt of due written proof of such loss. All claims shall be paid within 25 days following receipt by **Us** of due Proof of Loss when acceptable Proof of Loss is filed electronically and 35 days for Proofs of Loss filed in a format other than electronic. If payment

is not made within these timeframes, **We** will provide **You** with the reason(s) the claim is not payable or advise **You** of the additional information necessary to process the claim. Once such additional information is provided, the balance of the claim that is payable will be paid with 20 days of receipt of such additional information. Failure to pay within such time periods shall entitle **You** to interest at the rate of 1.5% per month from the date payment was due until final claims settlement or adjudication.

Under the section entitled **GENERAL PROVISIONS**, the following **ENTIRE CONTRACT** provision is added:

ENTIRE CONTRACT – The Certificate, including any endorsements and any attached papers constitute the entire contract of insurance. No change to this Certificate shall be valid until approved by an executive officer of the **Company** and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Certificate or to waive any of its provisions.

Under the section entitled **GENERAL PROVISIONS**, the following **CHANGE OF BENEFICIARY** provision is added:

The right to change the beneficiary is reserved to **You**. The consent of the beneficiary shall not be a prerequisite to the surrender of this Certificate or to any change of beneficiary, or any other changes to this Certificate.

NSHTC 2200 MS

Montana

Under the section entitled **GENERAL PROVISIONS**, the **CONTROLLING LAW** provision in its entirety and replaced with the following:

CONTROLLING LAW – The provisions of this Certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which You reside in on or after the effective date of this Certificate.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, exclusion 10 is deleted in its entirety.

NSHTC 2200 MT

Nebraska

The following amendments are made to **GENERAL PROVISIONS**:

The provision **DISAGREEMENT OVER SIZE OF LOSS** whenever stated in the Certificate is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement, either You or the Company can make a written demand for an appraisal. After the demand, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

The provision **MISREPRESENTATION AND FRAUD** in the General Provisions is deleted in its entirety and replaced with the following:

Your coverage shall be void if You concealed or misrepresented any material fact or circumstance concerning this Certificate, or subject thereof, in obtaining this insurance and such action or inaction deceived the Company to its injury. Also, Your coverage shall be void if You breach a warranty or condition in this Certificate at the time of a Loss and such breach contributes to the Loss.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

NSHTC 2200 NE

Nevada

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Pre-existing Condition** is deleted in its entirety and replaced with the following:

Pre-Existing Condition means a condition, regardless of the cause of the condition, applicable to You, a Traveling Companion, a Family Member booked to travel with You, or Your and/or a Traveling Companion's Family Member for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the

Effective Date of the new coverage. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

Under the section entitled **GENERAL PROVISIONS**, the **TIME OF PAYMENT OF CLAIMS** provision is deleted in its entirety and replaced with the following:

TIME OF PAYMENT OF CLAIMS - Benefits payable under this Certificate for any Loss other than Loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written Proof of such Loss. Subject to due written Proof of Loss, all accrued indemnities for Loss for which this Certificate provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof.

All claims shall be paid within thirty (30) days following receipt by the Company of due Proof of Loss. Failure to pay within such period shall entitle the claimant to interest at the rate equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the transaction, plus 2 percent per annum from the thirtieth (30th) day after receipt of such Proof of Loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. You or Your assignee shall be notified by the Company or designated representative of any known failure to provide sufficient documentation for a due Proof of Loss within thirty (30) days after receipt of the claim. Any required interest payments shall be made within thirty (30) days after the payment.

Under the section entitled **LIMITATIONS AND EXCLUSIONS**, Exclusion 6 is deleted in its entirety.

NSHTC 2200 NV

North Carolina

Page 1 of the Certificate is amended to include the following:

This program contains a Pre-existing Conditions limitation. Please read the Definitions and Exclusions carefully.

EXCESS INSURANCE

This Certificate is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim then the amounts of benefit payable by such other medical insurance will become the deductible amount of this Certificate if such benefits exceed the deductible amount shown in the Confirmation of Coverage.

Under the section entitled **GENERAL DEFINITIONS**, the definition of **Hospital** is revised by the addition of the following:

Hospital also means:

1. A place that is accredited as a **Hospital** by the Joint Commission on Accreditation of **Hospitals**, American Osteopathic Association, or the Joint Commission on Accreditation of Health Care Organizations (JCAHO).
2. A duly licensed State tax-supported institution, including those providing services for medical care of cerebral palsy, other orthopedic and crippling disabilities, mental and nervous diseases or disorders, mental retardation, alcoholism and drug or chemical dependency, and respiratory illness, on a basis no less favorable than the basis which would apply had the medical care been rendered in or by any other public or private institution or provider. The term "State tax-supported institutions" shall include community mental health centers and other health clinics which are certified as Medicaid providers.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** is deleted in its entirety and replaced with the following:

EXCESS INSURANCE LIMITATION - The insurance provided by this Certificate shall be in excess of all other valid and collectible insurance or indemnity other than private passenger auto no-fault benefits or third-party liability insurance. If at the time of the occurrence of any Loss there is other valid and collectible insurance or indemnity in place, the Company shall be liable only for the excess of the amount of Loss, over the amount of such Other Insurance or indemnity, and applicable Deductible.

Under the section entitled **GENERAL PROVISIONS**, the following apply to Accident Medical Expense and Sickness Medical Expense benefits.

The **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS – No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

The **SUBROGATION** provision does not apply to the above mentioned benefits.

The **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - The claimant must send the Company, or its designated representative, Proof of Loss within one-hundred and eighty (180) days after a covered Loss occurs or as soon as reasonably possible. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Under the section entitled **COORDINATION OF BENEFITS** the following changes apply:

Any reference to blanket insurance is deleted from the coordination of benefits provisions.

The **Right of Recovery** provision is deleted in its entirety.

NSHTC 2200 NC

North Dakota

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement, either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be binding. Such appraisal will be mutually agreed upon by all parties. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

NSHTC 2200 ND

Ohio

The following **FRAUD STATEMENT** and **COORDINATION OF BENEFITS** notices are added:

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

COORDINATION OF BENEFITS

If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the coordination of benefits section, and compare them with the rules of any other plan that covers you or your family.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives proof of loss. No legal action for a claim can be brought against the Company more than three (s) years after the time required for giving proof of loss.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** provision is deleted in its entirety. The reference to "Excess Insurance" on page 1 is deleted.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement, either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be non-binding. Such appraisal will be mutually agreed upon by all parties and any determination made is not binding on either party. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

Under the section entitled **GENERAL PROVISIONS**, the following **COMPLAINT** provision is added:

If you have a complaint related to a claim, You should contact the Company. If you disagree with the company's decision, you have the right to file a complaint with the Ohio Department of Insurance, Consumer Services Division, 2100 Stella Court, Columbus, Ohio 43215-1067, (614)-644-2673, toll free in Ohio 1-800-686-1526.

In the section entitled **COORDINATION OF BENEFITS**, the following changes are made:

The definition of **Plan** is amended to read:

Plan means a form of coverage with which coordination is allowed. The following will be considered in applying this COB provision.

Plan includes group insurance and group subscriber contract, an uninsured arrangement of group or group-type coverage, group or group-type coverage through a health insuring corporation or other prepayment, group practice or individual practice plan, group-type contracts, the amount by which group-type hospital indemnity benefits exceed one hundred dollars per day, medical benefits coverage under a group or group-type automobile "no fault" and traditional "fault" type contract, and Medicare or other governmental benefits, Medicaid or other plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

The term Plan shall not include an individual insurance contract, whether single or family coverage, an individual subscriber contract, whether single or family coverage, an individual contract with a health insuring corporation, whether single or family coverage, an individual contract under any other prepayment, group practice or individual practice plan, whether single or family coverage, group or group-type hospital indemnity benefits of one hundred dollars per day or less, a supplemental sickness and accident policy excluded from coordination of benefits because of the limited nature of the program pursuant to law, school accident-type coverage, a state plan under Medicaid, or other plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

The definition of **Allowable Expense** is amended to read:

Allowable Expense is the necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part under any of the Plans involved.

The difference between the cost of a private hospital room and a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an Allowable Expense and a benefit paid.

When plans have differing Allowable Expenses, the larger Allowable Expense shall be used for purposes of coordination. When benefits paid by a Primary Plan are less than the Allowable Expenses, the Secondary Plan shall pay or provide its

benefits toward any remaining balance otherwise payable by You. A Secondary Plan will not be required to make a payment of an amount that exceed the amount it would have paid if it were the Primary Plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the Secondary Plan exceed 100% of the larger of the expenses allowable under the provisions of the applicable policies.

Under the section entitled "Rules", items (c) and (d) are added:

(c) Children (Parents Divorced or Separated). If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the birthday rule.

(d) Children and the Birthday Rule. When your children's health care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children.

The following COORDINATION OF DISPUTES provision is added:

COORDINATION OF DISPUTES: If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. (For health maintenance organizations, reference Certificate's description of appeal procedures). If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

NSHTC 2200 OH

South Carolina

Under the section entitled **General Definitions**, the definition of Pre-Existing Condition is deleted in its entirety and replaced with the following:

Pre-Existing Condition means any injury, sickness or condition of You, Your Traveling Companion, Your Family Member booked to travel with You, or Your and/or a Traveling Companion's Family Member for which within the sixty (60) day period prior to the effective date under the Certificate such person received medical advice or treatment or medical advice or treatment was recommended. This definition does not apply to a condition that is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the sixty (60) day period before the Effective Date.

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than six (6) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the **EXCESS INSURANCE LIMITATION** provision is deleted in its entirety. The reference to "Excess Insurance" on page 1 is deleted.

Under the section entitled **GENERAL PROVISIONS**, the **PHYSICAL EXAMINATION AND AUTOPSY** provision is deleted in its entirety and replaced with the following:

PHYSICAL EXAMINATION AND AUTOPSY - The Company, or its designated representative, at its own expense, have the right to have You examined as often as reasonable necessary while a claim is pending. The Company, or its designated representative, also has the right to have an autopsy made unless prohibited by law. The autopsy will be performed in South Carolina.

NSHTC 2200 SC

Utah

Under the section entitled **GENERAL PROVISIONS**, the **PROOF OF LOSS** provision is deleted in its entirety and replaced with the following:

PROOF OF LOSS - You must furnish the Company, or its designated representative, with Proof of Loss. This must be a detailed sworn statement. It must be filed with the Company, or its designated representative, within ninety (90) days from the date of Loss. Failure to comply with these conditions shall not invalidate any claims under this Certificate if You can show it was not reasonably possible to file Proof of Loss within ninety (90) days.

NSHTC 2200 UT

Vermont

The following is added to the Certificate:

THIS TRAVEL PROGRAM IS A LIMITED BENEFIT PROGRAM. PLEASE READ YOUR CERTIFICATE CAREFULLY.

Under the section entitled **GENERAL PROVISIONS**, the **MISREPRESENTATION AND FRAUD** provision is deleted in its entirety and replaced with the following:

MISREPRESENTATION AND FRAUD – Your coverage shall be void if, before a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

Your coverage shall be cancelled and any claims denied if, after a Loss, You concealed or misrepresented any material fact or circumstance concerning this Certificate or the subject thereof, or Your interest therein, or if You commit fraud or false swearing in connection with any of the foregoing.

You must fully cooperate in the event the Company determines that an investigation of any claim is warranted.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS: If there is a disagreement about the amount of the Loss, upon mutual agreement, either You or the Company can make a written request for an appraisal. After the request, You and the Company will each select their own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will be binding. Such appraisal will be mutually agreed upon by all parties. The appraiser selected by You will be paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

Under the section entitled **GENERAL PROVISIONS**, the following is added to the **PAYMENT OF CLAIMS** provision:

After claim settlement has been agreed upon by You and the Company, the Company will mail payment in the agreed amount to You and/or the Loss payee within ten (10) working days. Failure to pay within such period shall entitle You to interest at the rate of nine percent (9%) per annum at the expiration of each four (4) weeks during the continuance of the period for which the Company is liable, provided that interest amounting to less than one dollar need not be paid. Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Under the section entitled **GENERAL PROVISIONS**, the following **CIVIL UNIONS** provision is added:

CIVIL UNIONS - This Certificate provides benefits for parties to a civil union. Vermont law requires that insurance policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this Certificate, the civil union must be established in the state of Vermont according to Vermont law. It is understood that Certificate definitions and provisions designating:

- an Insured
- named Insured
- who is Insured
- who is a named Insured
- covered person(s)
- You and/or Your
- spouse
- Family Member

and any other Certificate definitions and provisions designating an Insured under this Certificate, are amended, wherever appearing, where terms denoting a marital relationship or family relationship arising out of a marriage are used, to indicate parties to a civil union and their families under Vermont law.

NSHTC 2200 VT

West Virginia

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety and replaced with the following:

DISAGREEMENT OVER SIZE OF LOSS - If there is a disagreement about the amount of the Loss, upon mutual agreement,

either You or the Company can make a written request for an appraisal. You and the Company will each select its own competent appraiser. After examining the facts, each of the two appraisers will give an opinion on the amount of the Loss. If they do not agree, they will select an arbitrator. Any figure agreed to by two (2) of the three (3) (the appraisers and the arbitrator) will establish the amount of the claim. Such appraisal will be voluntary and will be by mutual consent by all parties. The appraiser selected by You is paid by You. The Company will pay the appraiser they choose. You will share equally with the Company the cost for the arbitrator and the appraisal process.

NSHTC 2200 WV

Wisconsin

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than three (3) years after the time required for giving Proof of Loss.

Under the section entitled **GENERAL PROVISIONS**, the **SUBROGATION** provision is deleted in its entirety and replaced with the following:

SUBROGATION - To the extent the Company pays for a Loss suffered by You, the Company will take over the rights and remedies You had relating to the Loss. This is known as subrogation. You must help the Company to preserve its rights against those responsible for the Loss. This may involve signing any papers and taking any other steps the Company may reasonably require. If the Company takes over Your rights, You must sign an appropriate subrogation form supplied by the Company. The Company's ability to recover is limited to the amount remaining after You have been made whole.

Under the section entitled **GENERAL PROVISIONS**, both of the **PROOF OF LOSS** provisions are deleted in their entirety and replaced with the following:

PROOF OF LOSS – Your or Your representative must send the Company, or its designated representative, Proof of Loss within ninety (90) days after a covered Loss occurs or as soon as reasonably possible. This must be a detailed sworn statement. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Failure to comply with these conditions shall invalidate any claims under this Certificate.

Under the section entitled **GENERAL PROVISIONS**, the **DISAGREEMENT OVER SIZE OF LOSS** provision is deleted in its entirety.

NSHTC 2200 WI

Wyoming

Under the section entitled **GENERAL PROVISIONS**, the **LEGAL ACTIONS** provision is deleted in its entirety and replaced with the following:

LEGAL ACTIONS - No legal action for a claim can be brought against the Company until sixty (60) days after the Company receives Proof of Loss. No legal action for a claim can be brought against the Company more than four (4) years after the time required for giving Proof of Loss.

NSHTC 2200 WY

CLAIMS PROCEDURE

1. EMERGENCIES ARISING DURING YOUR COVERED TRIP: Please contact On Call International (refer to Worldwide Emergency Assistance Services section).

2. ALL CLAIMS: Report your claim as soon as possible to Aon Affinity. Provide the policy number, Your travel dates, and details describing the nature of Your loss. Upon receipt of this information, Aon Affinity will promptly forward You the appropriate claim form to complete.

Online: www.travelclaim.com

Phone: 1-(800) 323-3153 or 1-(516) 342-7262

Mail: Aon Affinity Travel Practice
900 Stewart Avenue
Garden City, NY 11530-9998

Office Hours: 8:00 AM – 10:00 PM (EST), Monday – Friday
9:00 AM – 5:00 PM (EST), Saturday

Important: In order to facilitate prompt claims settlement upon your return, be sure to obtain as applicable: detailed medical statements from Physicians in attendance where the Accident or Sickness occurred; receipts for medical services and supplies; receipts from the Hospital; police reports or claims reports from the parties responsible (e.g. airline, cruise line, hotel, etc.) for any loss, theft, damage or delay. In the event of a baggage claim, receipts for any lost or damaged items will be required. In the event of a Baggage Delay or Trip Delay claim, receipts for any additional covered expenses will be required, as well as verification of the delay. You must receive initial treatment within ninety (90) days of the Accident, which caused the Injury, or the onset of the Sickness.

FACTS	WHAT DOES NATIONWIDE DO WITH YOUR PERSONAL INFORMATION?
Why?	Financial companies choose how they share your personal information. Federal and state laws give consumers the right to limit some but not all sharing. Federal and state laws also require us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: <ul style="list-style-type: none"> • Social Security number, government issued identification, and contact information • Medical information and policy information • Credit history, employment information, and insurance claim history
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Nationwide chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Nationwide share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliates to market to you	Yes	Yes

To limit our sharing	<ul style="list-style-type: none"> • Call us toll free at 1-866-280-1809 and our menu will prompt you through your choices. • If you have previously opted out, your preference remains on file and you do not need to opt out again. • Please have your account or policy number handy when you call. <p>Please note: If you are a <i>new</i> customer, we can begin sharing your information 30 days from the date we sent this notice. When you are <i>no longer</i> our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.</p>
Questions?	1-800-323-3153

Who we are	
Who is providing this notice?	Nationwide Mutual Insurance Company and Nationwide Mutual Fire Insurance Company (“Nationwide”).
What we do	
How does Nationwide protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state laws. These measures include computer safeguards and secured files and buildings. We limit access to your information to those who need it to do their job.
How does Nationwide collect my personal information?	We collect your personal information, for example, when you: <ul style="list-style-type: none"> • Apply for insurance or give us your contact information • Make a payment or file a claim • Conduct business with us We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal and state laws give you the right to limit only: <ul style="list-style-type: none"> • Sharing for affiliates' everyday business purposes—information about your creditworthiness; • Affiliates from using your information to market to you; and • Sharing for nonaffiliates to market to you. State laws and individual companies may give you additional rights to limit sharing. See below for more information.
What happens when I limit sharing for an account I hold jointly with someone else?	Your choices will apply to everyone on your account.
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. These companies include Nationwide Life Insurance Company, National Casualty, Nationwide Bank, and Nationwide Property and Casualty Insurance Company. Visit nationwide.com for a list of affiliated companies.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.
Other important information	
<p>California Residents: We currently do not share information we collect about you with affiliated or nonaffiliated companies for their marketing purposes. Therefore, you do not need to opt out.</p> <p>Nevada Residents: You may request to be placed on our internal Do Not Call list. Send an email with your phone number to privacy@nationwide.com. You may request a copy of our telemarketing practices. For more on this Nevada law, contact Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington St., Suite 3900, Las Vegas, NV 89101; Phone number: 1-702-486-3132; email: BCPINFO@ag.state.nv.us.</p> <p>For Vermont Customers: We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures.</p> <p>AZ, CA, CT, GA, IL, ME, MA, MT, NV, NJ, NM, NC, ND, OH, OR, and VA Residents: The Term “Information” means information we collect during an insurance transaction. We will not use your medical information for marketing purposes without your consent. We may share your Information with others, including insurance regulatory authorities, law enforcement, consumer reporting agencies, and insurance-support organizations without your prior authorization as permitted or required by law. Information obtained from a report prepared by an insurance-support organization may be retained by that insurance-support organization and disclosed to others.</p> <p>Accessing your information: You can ask us for a copy of your personal information. Please send your request to the address below and have your signature notarized. This is for your protection so we may prove your identity. Please include your name, address, and policy number. You can change your personal information at Nationwide.com. We can't change information that other companies, like credit agencies, provide to us. You'll need to ask them to change it.</p> <p style="text-align: center;">Aon Affinity Attn: Privacy Officer 900 Stewart Avenue Garden City, NY 11530-9998</p>	



NATIONWIDE® HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the “Notice”) applies to Nationwide¹ and describes the legal obligations of Nationwide, and your legal rights regarding your protected health information held by Nationwide under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Among other things, this Notice describes how your Protected Health Information (“PHI” as that term is defined below) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law.

Nationwide is required by HIPAA and certain state laws to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice so long as it remains in effect. Nationwide reserves the right to change the terms of this Notice and to make the new Notice effective for all PHI maintained by us, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of the revised Notice by mail to your last-known address on file.

Protected Health Information (PHI) includes individually identifiable health information that is created or received by Nationwide and that relates to: (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Certain uses and disclosures of PHI require your authorization. For example, most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require a written authorization. Except as outlined below, we will not use or disclose your PHI without your written authorization. If you have given us an authorization, you may revoke it in writing at any time, unless we have already acted on the authorization. Once we receive your written revocation, it will only be effective for future uses and disclosures.

Disclosures for Treatment, Payment or Health Care Operations. We may use or disclose your PHI as permitted by law for your treatment, payment, or health care operations. For instance, for your treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For health care operations, we may use and disclose your PHI for our health care operations, which include responding to customer inquiries regarding benefits and claims.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person’s involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times, it may be necessary for us to provide your PHI to one or more of these outside persons or organizations. For example, we may disclose your PHI to a business associate to administer claims or to provide support services. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness, and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

¹ Nationwide Life Insurance Company®, National Casualty Company and the area within Nationwide Mutual Insurance Company® that performs healthcare functions.

Plan Administration. We may release your PHI to your plan sponsor for administrative purposes, provided we have received certification that the information will be maintained in a confidential manner and not used in any other manner not permitted by law.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact as explained in the "Contact Information" section, below.

RIGHTS THAT YOU HAVE

Access to Your PHI. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Amendments to Your PHI. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact at the address provided in the "Contact Information" section.

Accounting for Disclosures of Your PHI. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Restrictions on Use and Disclosure of Your PHI. You have the right to request restrictions on some of our uses and disclosures of your PHI. We will consider, but are not required to agree to, your restriction request. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Request for Confidential Communications. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact at the address provided in the "Contact Information" section.

Right to be Notified of a Breach. You have the right to be notified in the event we discover a breach of your unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice, even if you have requested such copy by e-mail or other electronic means.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this Notice, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-800-323-3153, or mail your request to:

Aon Affinity
Attn: Privacy Officer
900 Stewart Avenue
Garden City, NY 11530-9998

EFFECTIVE DATE

This Notice is effective 7/5/17

Nationwide, the Nationwide framework, and On Your Side are federally registered service marks of Nationwide Mutual Insurance Company.

NH-0524-T-07052017

Worldwide Emergency Assistance Services

The following assistance services are provided by On Call International and are not an insurance benefit.

Not a care in the world...when you have our 24/7 global network to assist you on your travels.

- **CareFree™ Travel Assistance**
- **Medical Assistance**
- **Emergency Services**

CareFree™ Travel Assistance

Travel Arrangements

- Arrangements for last-minute flight and hotel changes
- Luggage Locator (reporting/tracking of lost, stolen or delayed baggage)
- Hotel finder and reservations
- Airport transportation
- Rental car reservations and automobile return
- Coordination of travel for visitors to bedside
- Return travel for dependent/minor children
- Assistance locating the nearest embassy or consulate
- Cash transfers
- Assistance with bail bonds

Pre-Trip Information

- Destination guides (hotels, restaurants, etc.)
- Weather updates and advisories
- Passport requirements
- Currency exchange
- Health and safety advisories

Documents and Communication

- Assistance with lost travel documents or passports
- Live email and phone messaging to family and friends
- Emergency message relay service
- Multilingual translation and interpretation services

Medical Assistance Services

- Medical case management, consultation and monitoring
- Medical Transportation
- Dispatch of a doctor or specialist
- Referrals to local medical and dental service providers
- Worldwide medical information, up-to-the-minute travel medical advisories, and immunization requirements
- Prescription drug replacement
- Replacement of eyeglasses, contact lenses and dental appliances

Emergency Services

- Emergency evacuation
- Repatriation of mortal remains
- Emergency medical and dental assistance
- Emergency legal assistance
- Emergency medical payment assistance
- Emergency family travel arrangements

CareFree™ Travel Assistance, Medical Assistance and Emergency Services can be accessed by calling On Call International at **1-866-509-7712** or, from outside the U.S. or Canada, call collect: **1-603-894-9386**.